

# Appendix 7

## Sample CMS 1500 Claim Form — Physician Radiology Services

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

Appendix

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234567890</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Recipient, Ima A.</b>					3. PATIENT'S BIRTH DATE <b>MM DD YY</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street) <b>609 Willow</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)			
CITY <b>Anytown</b>		STATE <b>WI</b>			CITY		STATE				
ZIP CODE <b>55555</b>		TELEPHONE (Include Area Code) <b>(XXX) XXX-XXXX</b>			ZIP CODE		TELEPHONE (INCLUDE AREA CODE)				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) <b>OI - P</b>					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH <b>MM DD YY</b> M <input type="checkbox"/> F <input type="checkbox"/>			b. EMPLOYER'S NAME OR SCHOOL NAME			
b. OTHER INSURED'S DATE OF BIRTH <b>MM DD YY</b> M <input type="checkbox"/> F <input type="checkbox"/>					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME			
c. EMPLOYER'S NAME OR SCHOOL NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>			
d. INSURANCE PLAN NAME OR PROGRAM NAME					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR <input type="checkbox"/> INJURY (Accident) OR <input type="checkbox"/> PREGNANCY(LMP) <b>MM DD YY</b>					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE <b>MM DD YY</b>			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <b>MM DD YY</b> TO <b>MM DD YY</b>			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE <b>I.M. Referring Physician</b>					17a. I.D. NUMBER OF REFERRING PHYSICIAN <b>11223344</b>			18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <b>MM DD YY</b> TO <b>MM DD YY</b>			
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. <b>V72.5</b> 3. _____ 4. _____					23. PRIOR AUTHORIZATION NUMBER			24. A DATE(S) OF SERVICE To B Place of C Type of D PROCEDURES, SERVICES, OR SUPPLIES E DIAGNOSIS CODE F \$ CHARGES G DAYS OR H EPSDT I J K RESERVED FOR LOCAL USE <b>MM DD YY MM DD YY Service Service CPT/HCPCS MODIFIER</b>			
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. <b>1234JED</b>			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) <b>J.M. Williams MM/DD/YY</b>					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			28. TOTAL CHARGE \$ <b>XX XX</b> 29. AMOUNT PAID \$ <b>XX XX</b> 30. BALANCE DUE \$ <b>X XX</b>			
SIGNED _____ DATE _____					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>I.M. Physician 1 W. Williams Anytown, WI 55555 87654321</b>			PIN# _____ GRP# _____			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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